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Frequently Asked Questions – Ohio Medicaid Provider Claims CES Edits

Effective February 22, 2016, CareSource removed 18 National/Local Coverage Determination (NCD/LCD) claims edits (listed below in Appendix A) that were deemed inappropriately applied to Medicaid claims. Claims containing affected procedure codes with dates of service from January 1, 2015, to February 22, 2016, are under review and will be reprocessed as applicable. Health partners were alerted to the change in LCD procedure code edits in a network notification posted on March 4, 2016.

In an effort to help our Ohio Medicaid health partners stay informed of how affected claims will be reprocessed, CareSource has created the following frequently asked questions (FAQs).

For any questions not addressed below, please contact Provider Services at 1-800-488-0134.

Appearance of Affected Claims on Explanation of Payments (EOPs)

Q: Can I obtain a list of all my affected claims that are going to be adjusted?

A: Your reprocessed claims will be incorporated with other claims that are processed that week. You should begin to see these adjustments on EOPs between now and the second week of May. Further inquiries about claims that have been reprocessed should be directed to your health partner representative.

Claims Reprocessing

Q: What is the projected timeframe for my claims to be reprocessed?

A: CareSource will reprocess all affected claims by May 6, 2016.

Q: What will the process be for deciding which claims will be reprocessed and which will not?

A: If a claim was denied for one of the edits listed in Appendix A and in the network notification from March 4 entitled “Change in LCD Procedure Code Edits,” CareSource will review it for reprocessing. If a claim is denied for a different reason, it will not be adjusted. All affected claims will be adjusted by May 6, 2016.

Q: What if I believe a claim that was denied for an LCD/NCD guideline not on the list should be reprocessed as well?

A: Follow the current CareSource policy for handling claim appeals. Fill out a Claim Appeal form and send it to: Claims Appeals Department, P.O. Box 2008, Dayton, OH 45401-8730.

Q: What if I locate a claim affected by one of the edits that does not get adjusted by May 6, 2016?

A: Even though CareSource is reprocessing claims, they may be denied for a different reason. Follow the current CareSource policy for handling claim appeals. Call Provider Services at 1-900-488-0134. You can also fill out a Claim Appeal form and send it to: Claims Appeals Department, P.O. Box 2008, Dayton, OH 45401-8730.

Q: What if my claim denies for a different reason once adjusted? – i.e., Claims past timely.

A: These claims will not deny for timely filing when adjusted. For questions on all other denials, follow the current CareSource policy for claim appeals. Call Provider Services at 1-900-488-0134. You can also fill out a Claim Appeal form and send it to: Claims Appeals Department, P.O. Box 2008, Dayton, OH 45401-8730.

Q: What if I believe claims prior to January 1, 2015, should be reprocessed?

A: Follow the current CareSource policy for claim appeals. Call Provider Services at 1-900-488-0134. You can also fill out a Claim Appeal form and send it to: Claims Appeals Department, P.O. Box 2008, Dayton, OH 45401-8730.

Q: What will the process be going forward for notifying me about any code adjustments that may impact claims?

A: CareSource has established a clinical edit oversight committee to review code adjustments that may impact claims.

Removed Edits Information

Q: Do the removed claims edits apply to all of Medicaid?

A: They apply to our Ohio and Kentucky Medicaid plans.

Q: Are both facility and professional claims affected?

A: Yes, both facility and professional claims are affected.

Q: Are edits that are being removed inclusive of all the LCD/NCD logic?

A: Yes, the edits being removed are inclusive of all LCD/NCD logic.

Appendix A

Below is a listing of the clinical coding edits that were removed, effective February 22, 2016:

Removed Clinical Edits	HIPAA Compliant HealthCare Claim Adjustment Code	Explanation Code
(BAG) LCD Part B Procedure Not Typical with Patient Age The BAG edit identifies claims containing CPT codes that can only be performed with a specified age per LCD/NCD.	6	LCD/ NCD: Age does not meet policy requirements for procedure or DX.
(BCC) LCD Part B Code to Code Missing or Invalid The BCC edit identifies claim lines that do not meet an LCD policies requirement for a code to code relationship.	A1	LCD/ NCD: CMS ID needs additional procedure code.
(BFR) LCD Part B Procedure Frequency Exceeded w/ CS Exclusions The BFR edit identifies a claim where a procedure code has been billed that exceeds frequency requirements for the policy.	B5	LCD/ NCD: Frequency does not meet policy requirements for procedure code.
(BPO) LCD Part B Invalid Place of Service-w/ CS Exclusions The BPO edit identifies claims containing CPT codes that can only be performed in specified Place(s) of Service per LCD/NCD policy.	58	LCD/ NCD: POS does not meet policy requirements for procedure code.
(BSP) LCD Part B Missing or Invalid Provider Specialty The BSP edit identifies claim lines that the provider specialty does not meet an LCD policies requirement.	8	LCD/ NCD: provider specialty does not meet policy for procedure code.
(BSX) LCD Part B Missing or Invalid Patient Gender The BSX edit identifies claims containing CPT codes that can only be performed on a specific gender per LCD/NCD.	7	LCD/ NCD: Patients gender does not meet policy requirements.
(LBI) LCD Part B Missing or Invalid Diagnosis-w/ CS Exclusions=many The LBI is issued if a diagnosis code does not meet guidelines for a policy with non- sequenced diagnosis codes.	146	LCD/ NCD: Diagnosis code(s), for procedure code is missing or invalid.
(LBM) LCD Part B Missing Required Modifier w/ CS Exclusions=many This edit identifies claims containing CPT codes that require a modifier per LCD/NCD guidelines.	182	LCD/ NCD: A modifier for procedure code is missing or invalid.
(LBP) LCD Part B Missing Required Primary Diagnosis w/ CS Exclusions The LBP is issued when a diagnosis code is required to be in a primary position and it is not or if the diagnosis in the primary position is not covered and the policy has	16	LCD/ NCD: A primary diagnosis code is missing or invalid.

sequencing requirements.		
(LBS) LCD Part B Missing Required Secondary Diagnosis w/ CS Exclusions The LBS is issued when the primary sequencing is met, and the diagnosis in the secondary position does not meet the secondary sequencing requirements.	16	LCD/ NCD: A secondary diagnosis code is missing or invalid.
(LBT) LCD Part B Missing Required Tertiary Diagnosis The LBT is issued when the primary sequencing is met, and the diagnosis in the tertiary position does not meet the tertiary sequencing requirements.	146	LCD/ NCD: A tertiary diagnosis code which meets medical necessity for procedure code is missing or invalid.
(LCAG) LCD Procedure Not typical with Patient Age Some LCD policies place conditions on what can, or cannot, be billed based on the patient's age. The LCAG flag is triggered when the patient age on the claim does not meet the requirement of an LCD/NCD policy.	6	Per LCD or NCD, the patient's age does not meet policy requirements for the procedure code and/or a diagnosis code.
(LCC) LCD Code to Code Missing or Invalid NCD and LCD policies outline several different requirements. There are policies that state a procedure code cannot be billed without another procedure code, this relationship is referred to as a code to code relationship. This pertains to add-on codes as well as other procedures.	A1	Per LCD or NCD guidelines, an additional procedure code is needed to meet policy requirements.
(LCDY) LCD Deny While most policies state that a claim can be paid if it meets the requirements of the policy, some policies specify that the claim line should be denied, or that documentation should be requested or reviewed. The edit action rule identifies the appropriate action to be taken when a claim or claim line matches the requirements of an NCD or LCD policy.	A1	Per LCD or NCD guidelines, procedure code has a denied relationship.
(LCFR) LCD Procedure Frequency Exceeded Some LCD policies limit the number of times that certain procedure codes can be billed. The LCFR flag is triggered when a procedure code does not meet the frequency requirements of an LCD/NCD policy.	B5	Per LCD or NCD, the frequency does not meet policy requirements for the procedure code
(LCG) LCD Inappropriate Gender Some LCD policies place conditions on what can, or cannot, be billed based on the patient's gender. The LCG flag is triggered when the patient gender on the line does not meet the requirement of an LCD/NCD policy.	7	Per LCD or NCD, the patient's gender does not meet policy requirements for the procedure code and/or a diagnosis code.

(LCI) LCD Missing or Invalid Diagnosis Code NCD and LCD policies outline the medical necessity requirements for many procedure codes. These requirements may include non-sequenced diagnosis.	146	Per LCD or NCD guidelines, a diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.
(LCM) LCD Missing Required Modifier NCD and LCD policies outline the medical necessity requirements for many procedure codes. These requirements may include non-sequenced diagnosis codes; primary, secondary, or tertiary diagnosis codes; or modifiers.	182	Per LCD or NCD guidelines, a modifier, which meets medical necessity for the procedure code is missing or invalid.
(LCON) LCD Missing or Invalid Condition Code(s) Some LCD policies place conditions on what can, or cannot, be billed based on the condition code(s) found on the claim. The LCON flag is triggered when the condition code(s) on the claim does not meet the requirement of an LCD/NCD policy.	16	Per LCD or NCD, the condition code(s) is missing or does not meet policy requirements for the procedure code.
(LCP) LCD Missing Primary Diagnosis Code NCD and LCD policies outline the medical necessity requirements for many procedure codes. These requirements may include non-sequenced diagnosis codes; primary, secondary, or tertiary diagnosis codes; or modifiers.	16	Per LCD or NCD guidelines, a primary diagnosis code, which meets medical necessity for the procedure code is missing or invalid.
(LCPf) LCD Profile While most policies state that a claim can be paid if it meets the requirements of the policy, some policies specify that the claim line should be denied, or that documentation should be requested or reviewed. The edit action rule identifies the appropriate action to be taken when a claim or claim line matches the Profile requirements of an NCD or LCD policy.	A1	Per LCD or NCD guidelines, procedure code has a profiled relationship. Please review the policy.
(LCRD) LCD Review/Request Documentation While most policies state that a claim can be paid if it meets the requirements of the policy, some policies specify that the claim line should be denied, or that documentation should be requested or reviewed. The edit action rule identifies the appropriate action to be taken when a claim or claim line matches the requirements of an NCD or LCD policy.	A1	Per LCD or NCD guidelines, documentation should be requested or reviewed for the procedure code
(LCS) LCD Missing Secondary Diagnosis Code NCD and LCD policies outline the medical necessity requirements for many procedure codes. These requirements may include non-sequenced diagnosis codes; primary, secondary, or tertiary diagnosis codes; or	16	Per LCD or NCD guidelines, a secondary diagnosis code, which meets

modifiers.		medical necessity for the procedure code, is missing or invalid.
(LCT) LCD Missing Tertiary Diagnosis Code NCD and LCD policies outline the medical necessity requirements for many procedure codes. These requirements may include non-sequenced diagnosis codes; primary, secondary, or tertiary diagnosis codes; or modifiers.	16	Per LCD or NCD guidelines, a tertiary diagnosis code, which meets medical necessity for the procedure code is missing or invalid.
(LDY) LCD Part B Deny w/ CS Exclusions=many The LDY edit is an edit action. If a claim line meets an LCD requirement, but the relationships says to deny it if the requirement is met, this flag is issued.	A1	LCD/ NCD: Procedure code has a denied relationship.
(LPF) LCD Part B Profile The LPF edit is an edit action. If a claim line meets an LCD requirement, but the relationships says profile it if the requirement is met, this flag is issued.	A1	LCD/ NCD: Procedure code is a profiled relationship. Please review.
(LRC) LCD Missing or Invalid Revenue Code Some LCD/NCD policies place conditions on what can, or cannot, be billed based on the revenue code submitted on the claim line. The LRC flag is triggered when the revenue code on the line does not meet the requirement of an LCD/NCD policy. The LCD Revenue Code rule will look at the current line on the claim for the revenue code. This rule does not need to consider other lines on the claim or in the patient's history.	5	Per LCD or NCD, the revenue code does not meet policy requirements for the procedure code.
(LRD) LCD Part B Review/Request Documents The LRD edit is an edit action. If a claim line meets an LCD requirement, but the relationship says to request or review documentation if the requirement is met, this flag is issued.	A1	LCD/ NCD: Documentation should be requested or reviewed.
(LTOB) Invalid Type of Bill Some LCD policies place conditions on what can, or cannot, be billed based on the type of bill. The LTOB flag is triggered when the type of bill on the claim does not meet the requirement of an LCD/NCD policy.	5	Per LCD or NCD, the type of bill does not meet policy requirements for the procedure code.
(LVC) LCD Missing or Invalid Value Code(s) Some LCD policies place conditions on what can, or cannot, be billed based on the value code(s). The LVC flag is triggered when the value code(s) on the claim does not meet the requirement of an LCD/NCD policy.	16	Per LCD or NCD, the value code(s) is missing or does not meet policy requirements for the procedure code.

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